

Total Paid \_\_\_\_\_

# of Days \_\_\_\_\_

# Navajo Nation Employee Benefits Program

## Report by Employer of Leave Status for Employee

\_\_\_\_\_ Opened

\_\_\_\_\_ Closed

\_\_\_\_\_ Reopened

\_\_\_\_\_ Closed

Member ID \_\_\_\_\_ (Inter-Office Use Only)

Employee's Name \_\_\_\_\_ Social Security No \_\_\_\_\_

Mailing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Date Last Worked \_\_\_\_\_ Date Returned to Work \_\_\_\_\_

Date Sick Leave Exhausted \_\_\_\_\_

*(If Sick Leave is not accrued, date would be the same date as Date Last Worked.)*

Date Employee is anticipated to return to work? \_\_\_\_\_

Employee must be totally disabled, be under a physician's care for the disability, exhaust sick leave hours, and satisfy all provisions and requirements for filing a claim. A seven (7) day waiting period applies for all non-occupational illness/maternity; no waiting period for a non-occupational injury. All information is subject to verification.

Dept/Prog \_\_\_\_\_ Dept No \_\_\_\_\_

Completed by (Print Name) \_\_\_\_\_ Tele No \_\_\_\_\_ Date \_\_\_\_\_

\*Please attach a current job description for insured employee\*